

Public Hearing Testimony Registration Form

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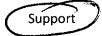


HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Testimony Registration Form

Facility Name: Quincy Medical Group Surgery, Quincy

III. POSITION (please circle appropriate position)



Oppose

Neutral

IV. Testimony (please circle)



Written



Project	Number:	18-042	
		•	

1.	IDENTIFICATION Name (Please Print)	JEAN	ALEXAN	JORE	JK
	city QUINCY	State	16	Zip_	62301
II.	REPRESENTATION (This section is to entity.) Entity, Organization, etc. represented the Health Care)				
	PHYSICIA	N			
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III.	POSITION tplease circle appro	priate position)		
	Support	Oppose	N	eutral	,
IV.	Testimony (please circle) Oral	Written			



Testimony (please circle)

Oral

Public Hearing Testimony Registration Form

Facility Name: Quincy Medical Group Surgery, Quincy

ı.	IDENTIFICATION, A.A.
	Name (Please Print) (an Val Ver)
	City Quncy State 12 zip 6734
II.	REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other
	entity.)
	Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for
	Health Care) Ovinces Medical avoid
	Khu Cician
	Q d d
	<u> </u>
111.	POSITION (please circle appropriate position)
	Support Oppose Neutral

Written



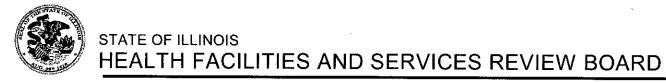
Facility Name: Quincy Medical Group Surgery, Quincy

	DENTIFICATION Name (<i>Please Pri</i>	17	w t	Leimbac	4			
c	City Qui	cf		State	TH	Zip	62301	-
e. E	REPRESENTATIC ontity.) Entity, Organizate Health Care)	•						
	Quincy	1 Mes	I: Cal	, Cro	e />			
-								-
I	POSITION (plea	se circle ap	propriate	position)				
(_	Support)		Oppose	Neu	ıtral		
4	Oral Oral	se circle)		Written				



Project	Number:	18-042
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1.	Name (Please Print) Tracey Klein
	city Micago State ILL zip 60611
II.	REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for
	Health Care) Representing Guincy Medical
	Group
	lum Polsinelli
1 11.	POSITION (please circle appropriate position)
	Support Oppose Neutral
IV.	Testimony (please circle) Oral Written



Project I	Number: 18-042			
I.	IDENTIFICATION Name (Please Print)	hn Barbagi	Ovanni	·
	City Divey	State		Zip 62301
11.	REPRESENTATION (This section is	to be filled if the witness is appe	aring on behalf of an	y group, organization or other
	entity.) Entity, Organization, etc. repr Health Care)			Concerned Citizens for
S PEAKING	IN LIEU DR C	DWENGA (DECEA	seD)	
	QuiNey	Dwenga (Decea Medical (nrou D.	
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· III.	POSITION (please circle appro	opriate position)		
	Support	Oppose	Neutral	
IV.	Testimony (please circle)		•	
	Oral	Written		

Projec	t Nu	ımber	: 18-	042
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IDENTIFICATION Name (Please Print)	John Barbagi	ovanni ř	v. O.
City QuiNey	State <u>III</u> ,	Nois	Zip 62301
entity.) Entity, Organization, etc. r	on is to be filled if the witness is appear epresented in this appearan		
Health Care)	ivey Medical	Group	
POSITION (please circle ap	opropriate position)		
Support	Oppose	Neutral	
Testimony (please circle)		•	
Oral	Written		

Facility Name: Quincy Medical Group Surgery, Quincy

IDENTIFICATION Name (Please Print)	1: chael C	Dwens	
city Peariq	State <u>12</u>	Zip	6162
REPRESENTATION (This section entity.)	is to be filled if the witness is appe	aring on behalf of any group,	organization or other
Entity, Organization, etc. re Health Care) Quiv	presented in this appeara		ned Citizens for
POSITION (please circle app	propriate position)		, (
Support	Oppose	Neutral	LANDIO
Testimony (please circle)		,	
Oral	Written	·	

Proiect	Number:	18-042
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IDENTIFICATION · Name (Please Print)	RALPH WEBE	R	
city RIVERWOO	State N	Zip	60015
REPRESENTATION (This section	on is to be filled if the witness is ap	pearing on behalf of any group,	organization or oth
entity.) Entity, Organization, etc. r. Health Care)	6	·	ned Citizens fo
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POSITION (please circle ap	ppropriate position)	· .	
Support	Oppose	Neutral	
Testimony (please circle)			
Oral	Written		•



Facility Name: Quincy Medical Group Surgery, Quincy

	IDENTIFICATION Name (Please Print)	chelle Fra	rier	
	city Quincy	State	こし Zij	62301
1.	REPRESENTATION (This section is entity.)			
	Entity, Organization, etc. reprinted Health Care) Quinty Media	esented in this appea		ned Citizens for
H.	POSITION (please circle appro	ppriate position)		·
	Support	Oppose	Neutral	<i>y</i> - *
ν.	Testimony (please circle)			
	Oral	Written		,



STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Testimony Registration Form

IDENTIFICATION Name (Please Print) City Quincy State IL Zip [27] REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization of entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens Health Care) Employer KNA PRETIDE POSITION (please circle appropriate position) Support Oppose Neutral			
REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens Health Care) Employer KNA PHEIDE POSITION (please circle appropriate position)		In Rusottin	M
REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens Health Care) Employen KNAPHEIDS POSITION (please circle appropriate position)	ime (Pieuse Print)	11m TOODS TO	
Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens Health Care) Employen Kuapheins POSITION (please circle appropriate position)	ty QuiNcy	State <u>エ</u> し	Zip 6238
Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens Health Care) Employen Kuaphens POSITION (please circle appropriate position)	/		
Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens Health Care) Employed Kuaphelina POSITION (please circle appropriate position)		is to be filled if the witness is appear	iring on behalf of any group, organization or oth
Health Care) Employen KNAPHEIDS POSITION (please circle appropriate position)	• •	presented in this appearan	nce (i.e., ABC Concerned Citizens fo
Employen KNAPHEIDS POSITION (please circle appropriate position)	·	F. TTOMES III CING SEPECTOR	
POSITION (please circle appropriate position)	•		
POSITION (please circle appropriate position)			
	SMD LOYER	KNAPHEIDS	
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	OSITION (please circle apr	propriate position)	•
Support Oppose Neutral	, , , , , , , , , , , , , , , , , , ,	,	
·	Support	Oppose	Neutral
Testimony (please circle)	stimony (<i>please circle</i>)		
Oral Written	_ ' <u>_</u>		



gect I	Number: 18-042			
1.	IDENTIFICATION Name (Please Print)	ely Helkey		·
	city <u>Owney</u>	State	L	zip_ <i>[0230]</i>
II.	REPRESENTATION (This section is to entity.)	be filled if the witness is app	pearing on behalf of any gr	oup, organization or other
	Entity, Organization, etc. repre Health Care)	sented in this appear	rance (i.e., ABC Cond	cerned Citizens for
	The TRI-State 1	Health Cale 7	Purchasing Co	aliton
III.	POSITION (please circle approp	oriate position)		
	Support	Oppose	Neutral	
IV.	Testim ony (please circle)			
	Oral	Written		



Project	Number:	18-042
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	Name (Please Print) Patty	William	1800	
(city Quincy	StateT	- L	zip 62301
	REPRESENTATION (This section is to be J	filled if the witness is app	earing on behalf of any gr	oup, organization or other
E	Entity, Organization, etc. represen Health Care) <u>Quincy Medica</u>			
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	POSITION (please circle appropria	te position)		
	Support	Oppose	Neutral	
. 7	Testimony (please circle)			
•	Oral	Written		



Project Number: :	18-042
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	ICATION	RICHARD SCHL	EAPHARST	M.J.
			_	
City(Z W NCY	State	L	ip <u> </u>
REPRESI entity.)	ENTATION (This sec	tion is to be filled if the witness is ap	opearing on behalf of any grou	p, organization or other ,
		represented in this appear	rance (i.e., ABC Conce	rned Citizens for
Health (are) QuiN	CY MEDICAL	G-ROUP	
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	 			•
POSITIO)N (please circle o	appropriate position)		•
Sup	port	Oppose	Neutral	
Testimo	ny (<i>please circle)</i>			
Oral	D .	Written		



Facility Name: Quincy Medical Group Surgery, Quincy

IDENTIFICATION Name (<i>Please Pri</i>	nt)	Todd P	etty		-
city Quin	щ	State	IL	zip 627	105
REPRESENTATIO	N (This section is to	o be filled if the witnes	ss is appearing on beho	alf of any group, organization	or other
Entity, Organiza Health Care)	ion, etc. repre	A	ppearance (i.e., i	ABC Concerned Citizer	ns for
			* 1		•
POSITION (pleas	e circle appro _l	priate position)			
Support)	Oppose	Ne	eutral	
Testimony (plea	e circle)				
(Oral)		Written			



STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Testimony Registration Form

Pro	ject	Num	ber:	18-042

IDENTIFICATION Name (Please Print)	urol Bri	ocknill	ev	
city Qq	State	Ul	zip(17301
REPRESENTATION (This section is the entity.) Entity, Organization, etc. represented the Health Care)		pearance (i.e., AE	Concerned C	
	11109 1013	- VOI C.VO(0 10 00	
		·		
POSITION (please circle appro	priate position)			·
Support	Oppose	Neu	tral	
Testimony (please circle)				
Oral	Written			